
An Assessment of Provider Behavior in Shared Professional Facilities



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AS DISCUSSIONS INTENSIFY on the possible shape and substance of national health insurance, it becomes essential to consider the impact of alternative proposals beyond narrowly defined programmatic objectives, such as increasing the public's ability to acquire services or minimizing the cost of catastrophic illness. Anderson (1) warned of the second-order consequences of innovative health programs, and he observed the

tendency of health planners to overlook consideration of possible, unanticipated effects and wider social ramifications of program plans while concentrating on desired outcomes.

In the view of White (2), one such area of concern should be the relationship "between the manner in which the patient finances his medical care, the manner in which the physician collects his earnings, and the manner in which his earnings are distributed to him," particularly as they relate to the influence of various payment systems on standards of care, levels of practitioner interest, and patient and provider satisfaction. Addressing this point, Brown (3) criticized government at all levels for not having used its power of financing to assure the delivery of adequate care to the poor while often surrendering to the power of the professional.

Financing schemes spawn new methods of delivery, as evidenced by emphasis on inpatient care where insurance contracts cover diagnostic procedures and the current proposals to develop health maintenance organizations, given the availability of Federal seed money. When a financing mechanism is followed by the development of new methods for delivery of care, evaluation efforts should be initiated to assess the validity of these configurations in light of program objectives, as

well as unanticipated consequences. While the need for such evaluation has long been apparent (4,5), recent studies have focused on consumer behavior when there is new access to medical care (6-9), with little attention to provider behavior when there is increased demand for services—perhaps because these studies were of demonstration projects in which provider behavior is predetermined by the program plan.

Since complete understanding of the implications of financing mechanisms requires studies of both consumer and provider behavior, such studies should be made in natural—rather than demonstration—practice settings where provider behavior can be examined. The need for investigations of provider behavior becomes especially important when one considers that 12 methods of providing ambulatory care have been identified, yet the extent to which each satisfies the criteria of comprehensiveness, accessibility, and quality of care has not been definitively determined (10).

Shared Professional Facilities

Health professionals who provide care for medical assistance (Medicaid) eligibles in New York City often practice in shared professional facilities (SPFs). While SPFs vary greatly, the New York City Department of Health has developed the following operational definition: “Three or more health care professionals providing services on the same premises and sharing a common waiting area, equipment, and/or supporting staff, one or more of whom bills the Medical Assistance Program on a fee-for-service basis.”

The estimated more than 300 SPFs currently operating in ghetto areas of New York City provide a natural setting for assessment of provider behavior in response to a program which lifts financial constraints on obtaining health care for a vast consumer group. While some SPFs have control systems that should promote quality of care, it has been found that generally there is a high degree of interrelationship among practitioners but little effort to develop linkage mechanisms between them for coordinated patient care. This finding indicates a need for development of prototype control systems and the designation of a governmental agency in a given jurisdiction to monitor their implementation and use as management information systems in order to evaluate provider behavior in a SPF.

In this paper, we describe a survey to evaluate the delivery of health care services in SPFs and discuss policy implications and the need for regulation of provider behavior when financing mechanisms increase consumer access to care.

Scope of SPFs

The sample for this study consisted of 32 shared professional facilities. They were selected randomly to represent the boroughs of New York City, because of differences in patient volume and in a few instances because of consumer complaints.

During the summer and fall of 1973, the 32 SPFs were visited by teams composed of a program research analyst and professional consultants (physicians, dentists, podiatrists, and optometrists) and a sanitarian from the health department. Specific visit dates were unannounced, although an announcement of the site visit program was mailed to each of the SPFs by the health department. When necessary, a health department employee telephoned, but did not identify himself or herself as a department employee, a SPF a week or so before the visit to find out what types of practitioners worked there so that appropriate professional consultants could be selected for the visit.

The SPFs vary in the numbers and types of health professionals they house—from a few practitioners in one profession only (for example, 5 physicians) to large multidisciplinary combinations (for example, 17 physicians, 5 podiatrists, 2 chiropractors, 4 dentists, and 3 optometrists). While physicians usually represent the largest single professional group in a facility, often they are exceeded in number by the total of other practitioners (for example, 5 physicians, 6 dentists, and 1 podiatrist).

The daily volume of patients in the 32 facilities ranges from less than 25 to 125 or more, as follows:

Daily patient volume	Facilities	
	Number	Percent
Less than 25	1	3
25-49	8	25
50-74	7	22
75-99	5	16
100-125	4	13
125 or more	7	21

The majority of the patients are on Medicaid; in nine of the facilities, 98 to 100 percent of the

patients receive medical assistance. The percentages of Medicaid patients in the 32 facilities are as follows:

<i>Percent Medicaid patients</i>	<i>Facilities</i>	
	<i>Number</i>	<i>Percent</i>
More than 90	19	60
80-89	7	22
70-79	3	9
69 or less	3	9

The predominant form of pecuniary relationship between the entrepreneur who owns the facility and the practitioners who provide services in it is a mechanism whereby the practitioner pays a fixed percentage (usually 40 to 50 percent) of his gross Medicaid billing to the entrepreneur. The financial arrangements in all 32 facilities are as follows:

<i>System</i>	<i>Facilities</i>	
	<i>Number</i>	<i>Percent</i>
Fixed rental	9	28
Percent of gross billing	10	32
Either percent of gross billing or fixed rental	11	34
Other	2	6

Assessment Criteria

The purpose of the assessment phase of the survey was to examine the extent to which services delivered within SPFs meet standards of continuity, coordination, accessibility, and acceptability. The measures used to make these standards operational are consistent with definitions and methodologies reported in the literature (11-13). For discussion purposes, criteria are classified as those relating to either structure or process.

The reader may conclude that we apply standards appropriate to group practice to SPFs. In our judgment, however, our criteria befit a system of care that falls between individual private practice and group practice as evidenced by SPFs which call themselves "family health centers," "groupe medico," and so on. Thus, while we do not have expectations for such mechanisms as team conferences to develop patient care plans or peer review, the criteria selected do consider the extent to which the SPF can attend to different types of patient care needs on an ongoing basis.

Structural criteria. Structural criteria deal with accessibility and coordination of care, monitoring of workload, emergency and inpatient care linkage mechanisms, the designation of a physician as

professional director, the organization of the record system, and the availability of full-time professional practitioners.

To determine whether care is accessible, a standard was developed which assumed that beyond routine weekday hours, services should be available evenings (after 5 pm) and on Saturdays. The basis of the assumption is that services should be available to patients without interfering with their workday or school attendance, nor should obtaining services necessitate complex personal arrangements (for example, babysitters and use of taxis).

To facilitate coordinated care by designated practitioners, appointment systems must allow adequate time for practitioner-patient contact. While first visits may be of necessity on a walk-in basis, followup and referrals should be on an appointment basis to allow, for example, time for the practitioner to review the charts of patients who fail to keep revisit appointments and the initiation of patient contact if indicated.

A daybook containing records of all appointments kept and broken as well as of walk-in patients should be maintained in order to monitor activity at the facility. Such monitoring permits a determination if the quality of care delivered may be jeopardized by patient volume and an assessment of the referral relationship among practitioners.

A formal system for emergency care during hours when the facility is closed should be in operation, whether in the form of an answering service or a designated hospital emergency department. A SPF should also have a formal arrangement with a backup facility so that bed availability is maximized and to promote admissions to hospitals in or near the catchment area of the SPF.

It is desirable that the professional director of an SPF be a physician who is onsite to coordinate operations, in particular, to develop written policies and procedures for triage of walk-in patients, referrals among practitioners at the facility and offsite, and use of ancillary services. The professional director should also be responsible for the maintenance of the daybook, the management of the record system, emergency arrangements, and transfer agreements with inpatient facilities.

An optimal record system would be completely centralized, with all practitioners in all professions sharing the same charts. Thus, for example, medical histories are available to the

dentists and optometrists, and a complete record with input from all professions is available to the hospital-based practitioner who may coordinate care upon admission. If each profession maintains its own charts (shared by all practitioners within that profession) abstracts should be prepared for the records maintained by other professions; thus, for example, a dentist is aware of critical medical problems that may affect his treatment decisions. A completely decentralized record system where each practitioner maintains his own records is least desirable because there is no written intraprofessional or interprofessional communication, although there may be an extensive amount of patient referrals among the various types of practitioners within a facility.

The final structural criterion focuses on the extent to which practitioners work full time (31 hours or more of patient contact per week), with particular emphasis on the number of full-time primary medical and dental practitioners, since continuous care may be compromised if primary practitioners are available only on a limited basis. It is assumed that as a minimum at least one full-time medical practitioner should be available in each SPF so that walk-in patients can be seen by a generalist rather than by a part-time specialist who may be onsite.

Process criterion. The process criterion relates to the outcome of professional audits. Medical, dental, podiatric, and optometric audits are accomplished as part of the assessment process by practitioners in these professions who serve as health department consultants. A satisfactory rating on the medical audit is based on evidence of complete histories and physical examinations, documented followup care, annotated referrals, and recording of medications prescribed, laboratory and radiologic tests ordered, and immunizations given. A satisfactory rating on the dental, podiatric, and optometric audits is based on a sufficient recordkeeping system, adequate equipment, and indications that the patients are afforded comprehensive rather than only one-visit episodic care. Thus, the professional auditors do not attempt to assess the efficacy of care but basically determine whether information on the patient care process is recorded in a satisfactory or unsatisfactory manner. These standards are logical extensions of audit procedures of private practitioners who bill the New York City Medical Assistance Program (14-18).

Findings

Since the entrepreneurs generally feel that they are dealing with independent practitioners and therefore are not responsible for monitoring professional activity, management information systems typical of neighborhood health centers, for example, are not evident. Program assessment data are collected by the study teams during the visits by using a detailed questionnaire to interview administrators and practitioners, as well as by checking signs, bulletin boards, worksheets, and practitioners' schedules. Efforts are made to validate information by obtaining it from multiple sources within the facility to the greatest extent possible. For the most part, SPF personnel have cooperated with the site visit team.

Structural criteria. Accessibility of care, as measured by the availability of evening, Saturday, and Sunday sessions, is satisfactory in 19 of the 32 facilities. At the remaining 13 sites, the standard is either completely unsatisfied (1 site) or only partially satisfied (12 sites). The availability of care beyond routine weekday hours follows:

System	Facilities	
	Number	Percent
Evenings and Saturdays	18	56
Evenings, Saturdays, and Sundays	1	3
Saturdays, no evenings	10	32
Evenings, no Saturdays	1	3
Saturdays, Sundays, no evenings	1	3
None	1	3

For the most part, appointment systems are not in effect in the SPFs. Eight of the facilities observed have no appointment system whatsoever; therefore, 100 percent of their patients are walk-ins. As the following percentages show, a walk-in rate of more than 80 percent is more than typical:

Percent walk-in patients	Facilities	
	Number	Percent
100	8	25
90-99	4	12
80-89	6	19
70-79	3	9
60-69	3	9
50-59	5	17
less than 50	3	9

Of the 32 SPFs, 15 keep daybooks. Thus, in more than half of the facilities patient volume is not evaluated, and referral patterns among practitioners are not monitored. Only six of the SPFs have emergency arrangements, and only four have formal arrangements with backup facilities.

While 13 of the 32 SPFs have professional directors, 5 have neither a professional director

Table 1. Types of record systems in 32 shared professional facilities

Type	Fully implemented	Partially implemented	Total ¹
Completely centralized ²	4	0	4
Centralized by profession ³	6	18	24
Completely decentralized ⁵	4	18	22
Total	14	36	50

¹ Total is more than 32 because many facilities have dual systems operating simultaneously.

² All practitioners use the same charts.

³ All practitioners within a profession use the same charts.

⁴ These 2 types always appear together in the sample where partial implementation is observed.

⁵ Each practitioner maintains his own charts.

nor an administrator and thus a complete absence of any managerial control. The management characteristics of the facilities follow:

Management	Facilities	
	Number	Percent
Professional director:		
Yes	13	41
No	19	59
Administrator:		
Yes	26	81
No	6	19
Professional director or administrator:		
Neither	5	16
Both	12	38
Administrator only	14	43
Professional director only	1	3

The types of record systems observed are shown in table 1. Although only four facilities have a completely centralized system, it is important to note that none of these have dentists on their staff. Invariably, dentists maintain their own records.

Finally, continuous primary medical care may well be compromised since only 27 percent of

the primary practitioners work full time and 31 percent work only 10 hours or less a week in the SPFs (table 2). At 7 of the 28 sites observed on this dimension, no full-time primary medical practitioner is available.

Process criterion. The outcomes for 13 of the 32 medical audits, 14 of the 19 dental audits, and 5 of the 14 podiatric audits meet the standards described, indicating that satisfactory care is often available at SPFs although not universally and at different levels for different professions (table 3). Again, these standards are related primarily to the recording of patient care information based on the assumption that what is not recorded in the chart is useless, regardless of the clinical capability of the practitioner.

Discussion

The findings suggest that while quality of care as assessed through professional audits is often satisfactory, the criteria of accessibility, continuity, and coordination are not satisfied in SPFs. From observations at the 32 facilities, it seems that a type of group practice has evolved that is based on a pecuniary relationship with little professional or managerial control.

Since accessibility is often not optimal, it may well be that patients use SPFs when convenient but obtain services elsewhere (for example, hospital emergency departments, other SPFs, or offices of private practitioners) when the SPF is closed. If obstacles to accessibility necessitate obtaining services from multiple sources, the problems usually associated with fragmented care—such as lack of practitioner continuity and the nondevelopment of comprehensive health care records—ensue.

Table 2. Number and percent of practitioners in 28 shared professional facilities, by number of hours they work per week

Practitioners	31 hours or more		21–31 hours		11–20 hours		6–10 hours		5 hours or less		Total number practitioners
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Primary medical practitioners ¹	28	27	18	17	26	25	14	14	18	17	104
Medical specialists	1	1	5	5	6	6	29	29	58	59	99
Dentists	14	61	3	13	4	18	1	4	1	4	23
Podiatrists	8	25	6	19	4	12	13	41	1	3	32
Optometrists	2	29	0	0	4	57	1	4	0	0	7
Chiropractors	1	12.5	1	12.5	2	25	4	50	0	0	8
Total	54	20	33	12	46	17	62	23	78	28	273

¹ General practitioners, internists, pediatricians, and osteopaths.

Table 3. Outcome of professional audits in 32 shared professional facilities

Type of audit	Excellent		Satisfactory		Unsatisfactory		Total audits
	Number	Percent	Number	Percent	Number	Percent	
Medical.....	4	13	9	28	19	59	32
Dental.....	0	0	14	74	5	26	19
Podiatric.....	0	0	5	36	9	64	14
Optometric.....	0	0	0	0	1	100	1
Total.....	4	6	28	42	34	52	66

The high walk-in rate suggests that followup visits are as much patient initiated as practitioner ordered, that often no mechanism exists to assure that the patient receives coordinated rather than episodic care, and that patients may well be receiving care from more than one primary practitioner within a profession.

The finding that 17 of the SPFs do not maintain daybooks means that they have no mechanism to assure that enough time is allotted for appointments, to allow quality care and to make certain that referrals are medically indicated.

The general lack of any emergency arrangements or any formal arrangements with backup facilities suggests that both emergency and inpatient care are poorly integrated with ambulatory care, if not completely divorced. Patient care is compromised when linkage mechanisms between different entry points into the health care systems have not been properly developed.

As indicated, many SPFs lack managers. Without managers, essential systems such as the use of a daybook, emergency arrangements, and formal agreement with a backup facility are unlikely to be implemented.

The high number of partially decentralized or completely decentralized record systems suggests that communication among practitioners is minimal. At sites where charts are centralized by profession, no abstracts of work done by other professions were observed.

That dual systems often operate simultaneously may be particularly problematic. For example, all primary medical practitioners, some medical specialists, and the podiatrists may share centralized charts, whereas other medical specialists, dentists, and optometrists maintain their own records. Thus, in some cases intraprofessional and interprofessional communication takes place, but in others it is nonexistent. Practitioners may assume that information is being shared because one set

of a patient's experiences is attributed to another set of experiences; this attribution may be entirely inappropriate and, of course, injurious to the patient.

Primary care is the core around which all other services should be coordinated. The predominant pattern of part-time primary medical practitioners raises critical questions as to the extent to which patient care is continuous or coordinated within SPFs.

Although entrepreneurs of SPFs state that they house independent practitioners, the following evidence suggests extensive interrelationship among the practitioners.

- The SPFs observed are primarily moderate to high-volume operations catering to patients on medical assistance, with noticeable interdisciplinary referral patterns. In at least eight SPFs, onsite referrals appear excessive, and the need for such referrals remains essentially undocumented. Moreover, it is often unclear which practitioner, if any, takes overall responsibility for coordinating a given patient's care.

- The predominant factor in the pecuniary relationship between entrepreneur and practitioners is that the former receives a fixed percentage of the latter's gross billing to Medicaid. Thus, the most financially rewarding type of operation is one which has a high volume of patients and which allows only a short time for practitioner-patient contact.

- Since a significant portion of the visits are on a walk-in basis and most of the practitioners work part time in the facilities observed, it is likely that patients needing primary medical care see only the available practitioner, who may be a part-time specialist rather than a predesignated generalist.

- The practitioners often share X-ray equipment (28 sites) and clinical laboratory facilities (15 sites), as well as associated technicians.

- Record systems at all but four sites (where there is complete decentralization) are somewhat integrated, indicating a decision to cooperate to some extent by the practitioners.
- Of the 32 facilities, 26 employ administrators who are partly responsible for deploying the shared ancillary personnel among practitioners (for example, medical and dental assistants), and 13 have professional directors who monitor professional activities.
- Daybooks are kept by 15 of the facilities to allow evaluation of volume and referral patterns or to allow the entrepreneur to monitor activity in order to assess his financial position.

Despite the obvious group practice type of relationship seen in the 32 facilities, there is little indication of efforts to self-regulate or to monitor provider behavior and responsibility.

Conclusions and Recommendations

Pauly (19) stated that "fee-for-service reimbursement methods provide a strong productivity-increasing incentive" and "since the physician's income under such a system varies directly with the number of units of service rendered, one might expect the fee-for-service system to induce the physician to try to get patients to consume more units of service than they would have consumed under other kinds of reimbursement." His assumption is borne out by the findings of this study and accentuated in the SPF setting by the usual financial agreement between entrepreneur and provider where volume benefits both parties.

The findings suggest that controls are needed to insure that adverse second-order consequences as manifested in some types of provider behavior are not deleterious to the consumers. The potency of controls is demonstrated by the statistical relationship between having a professional director and a satisfactory rating on the medical audit ($X^2 = 3.97, P = .05$) and having a daybook and a satisfactory rating on the medical audit ($X^2 = 4.39, P = .05$), as shown in the following figures for the 32 facilities.

<i>Medical audit</i>	<i>Professional director</i>		<i>Daybook</i>	
	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
Satisfactory	8	5	9	¹ 4
Unsatisfactory	5	14	6	13

¹ Expected value of 6.9

The composite picture of dental practice in the SPFs is quite encouraging (74 percent satisfactory rating on professional audits) and must

partly be attributed to the level of full-time dentists (61 percent) compared with the other professional staff (tables 2 and 3).

With controls such as a designated professional director, a daybook, hours of service that promote accessibility, appointment systems emphasizing fixed followup and referral appointments, formal emergency and backup facility arrangements, functional record systems, and a minimum acceptable number of full-time primary practitioners, the adequate delivery of care noted in a number of SPFs should become more evident in general.

Implications

Configurations such as shared professional facilities exemplify likely provider behavior when financial constraints are lifted on consumer access to health care services, particularly in ghetto areas or where there is a dearth of service sources. The concern of all parties must be the quality of the delivery of care and not an abstract polemic on the delivery of health services in the urban ghetto. SPFs may well fill a gap that more traditional institutions and providers have either failed or chosen not to satisfy. To insure the effectiveness of SPFs, however, standards are needed for the delivery of care and the monitoring of provider performance.

To achieve acceptance and enforcement of governmentally defined standards, the professions at which these standards are aimed and consumer representatives should participate in developing the guidelines. Initial emphasis should be on criteria that apply to professional activity in either the individual private practice or the group practice setting in order to focus discussion on standards rather than on the issue of whether or not shared professional facilities are group practices. Particularly important in this regard are appointment systems, arrangements for emergency care, transfer agreements with inpatient institutions, and well-documented medical records.

Regardless of legislative intent, second-order consequences such as the provider behavior reported here are still possible. Given this potential, government must assume the responsibility for regulation.

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METSCH, JONATHAN M. (City University of New York), SCHWARZ, AL, and DONN, WENDY: *An assessment of provider behavior in shared professional facilities. Public Health Reports, Vol. 89, July–August 1974, pp. 307–314.*

Unanticipated second-order consequences of health programs when financial constraints are lifted may become manifest in both consumer and provider behavior. While consumer behavior in such programs has been well studied, little attention has been directed to provider behavior when there is increased demand for care.

In New York City more than 300 shared professional facilities (SPFs) have opened in ghetto areas to provide services to medical assistance (Medicaid) eligibles. While the SPFs vary greatly, the New York City Health Department has developed the following definition: "Three or more health professionals provid-

ing services on the same premises and sharing a common waiting area, equipment, and/or supporting staff, one or more of whom bills the Medical Assistance Program on a fee-for-service basis."

To assess the extent to which comprehensive, coordinated, continuous, and accessible care is provided in a sample of 32 SPFs in the boroughs of New York City, a site-visit study was conducted. Teams composed of a program research analyst, professional consultants, and a sanitarian looked at practitioner workload, management information and control systems, emergency and inpatient care linkage mechanisms, the designation and role of a professional director,

the organization of record systems, the availability of full-time practitioners, and the adequacy of information recorded on patients' charts.

The results of the study suggest that a type of group practice has evolved which is based on a pecuniary relationship with little in the way of professional and managerial controls. To assure effective delivery of care, a designated professional director, a daybook, hours of service that promote accessibility, appointment systems, emergency and backup facility arrangements, functional record systems, and a minimum level of full-time practitioners are needed.
